



Georgia Department of Motor Vehicle Safety

2206 East View Parkway • Conyers, Georgia 30013 • 678.413.8650

Physical Examination Certificate

General Information

Name: _____
(First) (Middle) (Last)

Address: _____
(Street) (City) (State) (Zip Code)

Date of Birth: _____
(Month) (Day) (Year)

Name of School (Employed): _____ School License Number: _____

School Address

Street: _____

City: _____

County: _____

Zip: _____

Applicant cannot be absent of one eye, hand or foot. If any arm or leg is amputated, stiff or paralyzed to the extent it has lost its normal use; a Driver Education Instructor License will not be issued.

Health History

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Head or Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>	Communicable Disease
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Fits, Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Any Incurable Disease
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Sickness	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ever Confined as Invalid	<input type="checkbox"/>	<input type="checkbox"/>	Permanent Defect as Result of Disease or Accident
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis

Other illness or injuries: _____

Physical Information

General appearance and development: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____

Head:

Eyes for Distance (without glasses/contacts): Right 20 / _____ Left 20 / _____

Eyes for Distance (with glasses/contacts): Right 20 / _____ Left 20 / _____

Evidence of injury: Right: _____ Left: _____

Color Vision: _____ Horizontal Field: Right: _____ Left: _____

Ears (Hearing @ 20 ft.): Right: _____ Left: _____



Thorax:

Heart: _____

If Organic disease is present, is it fully compensated? ☐ Yes ☐ No

Blood Pressure (Sitting): Systolic: _____ Diastolic: _____

Pulse: Before Exercise: _____ Two Minutes After Exercise: _____

Lungs: _____

Abdomen:

Scars: _____ Abnormal Masses: _____ Tenderness: _____

Hernia: ☐ Yes ☐ No If so, where: _____

Gastro-Urinary:

Scars: _____ Urethral Discharge: _____

Extremities:

Upper: _____

Lower: _____

Spine: _____

Laboratory Findings:

Urine: Spec. Gr.: _____ Alb: _____ Sugar: _____

Drug Screening Results Report (Negative or Positive):

Copies of all Laboratory Results Reports for Drug Screening must be attached to this Physical Examination Certificate. Test for Drug Screening should include as a minimum: Amphetamines, Cocaine Metabolites, Marijuana Metabolites, Opiates, and Phencyclidine.

NOTE: Test must be done within thirty (30) days of filing application.

Doctor's Certificate

This is to certify that I have this _____ Day of _____, 20 _____
examined _____ and that I find his/her physical condition is sufficiently sound to perform
the duties required by a Driver Training Instructor

Signature of Examining Doctor

Printed Name of Examining Doctor

Address of Examining Doctor

License Number of Examining Doctor